

E-052-17

RECEIVED

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD

APPLICATION FOR EXEMPTION PERMIT

DEC 13 2017

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects.

HEALTH FACILITIES &
SERVICES REVIEW BOARD
ORIGINAL**Facility/Project Identification**

| | | | |
|--------------------|--|---------------------|--------------------------------|
| Facility Name: | AMITA Health Alexian Brothers Medical Center | | |
| Street Address: | 800 Biesterfield Road | | |
| City and Zip Code: | Elk Grove Village, IL 60007 | | |
| County: | Cook | Health Service Area | VII Health Planning Area: A-07 |

Applicant(s) [Provide for each applicant (refer to Part 1130.220)]

| | |
|-------------------------------------|--|
| Exact Legal Name: | Alexian Brothers Medical Center d/b/a AMITA Health Alexian Brothers Medical Center |
| Street Address: | 800 Biesterfield Road |
| City and Zip Code: | Elk Grove Village, IL 60007 |
| Name of Registered Agent: | C T Corporation System |
| Registered Agent Street Address: | 208 S. LaSalle Street Suite 814 |
| Registered Agent City and Zip Code: | Chicago, IL 60604 |
| Name of Chief Executive Officer: | John Werrbach |
| CEO Street Address: | 800 Biesterfield Road |
| CEO City and Zip Code: | Elk Grove Village, IL 60007 |
| CEO Telephone Number: | 847/437-5500 |

Type of Ownership of Applicants

| | |
|--|---|
| <input checked="" type="checkbox"/> Non-profit Corporation | <input type="checkbox"/> Partnership |
| <input type="checkbox"/> For-profit Corporation | <input type="checkbox"/> Governmental |
| <input type="checkbox"/> Limited Liability Company | <input type="checkbox"/> Sole Proprietorship <input type="checkbox"/> Other |

- Corporations and limited liability companies must provide an **Illinois certificate of good standing**.
- Partnerships must provide the name of the state in which they are organized and the name and address of each partner specifying whether each is a general or limited partner.

APPEND DOCUMENTATION AS ATTACHMENT 1 IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Primary Contact [Person to receive ALL correspondence or inquiries]

| | |
|-------------------|---|
| Name: | Jacob M. Axel |
| Title: | President |
| Company Name: | Axel & Associates, Inc. |
| Address: | 675 North Court, Suite 210 Palatine, IL 60067 |
| Telephone Number: | 847/776-7101 |
| E-mail Address: | jacobmaxel@msn.com |
| Fax Number: | 847/776-7004 |

Additional Contact [Person who is also authorized to discuss the application for exemption permit]

| | |
|-------------------|------|
| Name: | none |
| Title: | |
| Company Name: | |
| Address: | |
| Telephone Number: | |
| E-mail Address: | |
| Fax Number: | |

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR EXEMPTION PERMIT
SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects.

Facility/Project Identification

| | | | |
|--------------------|--|---------------------|--------------------------------|
| Facility Name: | AMITA Health Alexian Brothers Medical Center | | |
| Street Address: | 800 Biesterfield Road | | |
| City and Zip Code: | Elk Grove Village, IL 60007 | | |
| County: | Cook | Health Service Area | VII Health Planning Area: A-07 |

Applicant(s) [Provide for each applicant (refer to Part 1130.220)]n

| | |
|-------------------------------------|----------------------------------|
| Exact Legal Name: | Ascension Health |
| Street Address: | 4600 Edmunson Road |
| City and Zip Code: | St. Louis, MO 63134 |
| Name of Registered Agent: | Illinois Corporation Service C |
| Registered Agent Street Address: | 801 Adlai Stevenson Drive |
| Registered Agent City and Zip Code: | Springfield, IL 62703 |
| Name of Chief Executive Officer: | Anthony R. Tersigni, Ed.D, FACHE |
| CEO Street Address: | 4600 Edmunson Road |
| CEO City and Zip Code: | St. Louis, MO 63134 |
| CEO Telephone Number: | 314/737-8000 |

Type of Ownership of Applicants

| | |
|--|---|
| <input checked="" type="checkbox"/> Non-profit Corporation | <input type="checkbox"/> Partnership |
| <input type="checkbox"/> For-profit Corporation | <input type="checkbox"/> Governmental |
| <input type="checkbox"/> Limited Liability Company | <input type="checkbox"/> Sole Proprietorship <input type="checkbox"/> Other |

- o Corporations and limited liability companies must provide an **Illinois certificate of good standing**.
- o Partnerships must provide the name of the state in which they are organized and the name and address of each partner specifying whether each is a general or limited partner.

APPEND DOCUMENTATION AS ATTACHMENT 1 IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Primary Contact [Person to receive ALL correspondence or inquiries]

| | |
|-------------------|---|
| Name: | Jacob M. Axel |
| Title: | President |
| Company Name: | Axel & Associates, Inc. |
| Address: | 675 North Court, Suite 210 Palatine, IL 60067 |
| Telephone Number: | 847/776-7101 |
| E-mail Address: | jacobmaxel@msn.com |
| Fax Number: | 847/776-7004 |

Additional Contact [Person who is also authorized to discuss the application for exemption permit]

| | |
|-------------------|------|
| Name: | none |
| Title: | |
| Company Name: | |
| Address: | |
| Telephone Number: | |
| E-mail Address: | |
| Fax Number: | |

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR EXEMPTION PERMIT
SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects.

Facility/Project Identification

| | | | |
|--------------------|--|---------------------|--------------------------------|
| Facility Name: | AMITA Health Alexian Brothers Medical Center | | |
| Street Address: | 800 Biesterfield Road | | |
| City and Zip Code: | Elk Grove Village, IL 60007 | | |
| County: | Cook | Health Service Area | VII Health Planning Area: A-07 |

Applicant(s) [Provide for each applicant (refer to Part 1130.220)]

| | |
|-------------------------------------|---|
| Exact Legal Name: | Alexian Brothers-AHS Midwest Region Health Co. d/b/a AMITA Health |
| Street Address: | 3040 West Salt Creek Road |
| City and Zip Code: | Arlington Heights, IL 60005 |
| Name of Registered Agent: | C T Corporation System |
| Registered Agent Street Address: | 208 S. La Salle Street, Suite 814 |
| Registered Agent City and Zip Code: | Chicago, IL 60604 |
| Name of Chief Executive Officer: | Mark A. Frey |
| CEO Street Address: | 3040 West Salt Creek Road |
| CEO City and Zip Code: | Arlington Heights, IL 60005 |
| CEO Telephone Number: | 847/815-5100 |

Type of Ownership of Applicants

| | | |
|--|--|--------------------------------|
| <input checked="" type="checkbox"/> Non-profit Corporation | <input type="checkbox"/> Partnership | |
| <input type="checkbox"/> For-profit Corporation | <input type="checkbox"/> Governmental | |
| <input type="checkbox"/> Limited Liability Company | <input type="checkbox"/> Sole Proprietorship | <input type="checkbox"/> Other |
| <ul style="list-style-type: none">o Corporations and limited liability companies must provide an Illinois certificate of good standing.o Partnerships must provide the name of the state in which they are organized and the name and address of each partner specifying whether each is a general or limited partner. | | |
| APPEND DOCUMENTATION AS ATTACHMENT 1 IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM. | | |

Primary Contact [Person to receive ALL correspondence or inquiries]

| | |
|-------------------|---|
| Name: | Jacob M. Axel |
| Title: | President |
| Company Name: | Axel & Associates, Inc. |
| Address: | 675 North Court, Suite 210 Palatine, IL 60067 |
| Telephone Number: | 847/776-7101 |
| E-mail Address: | jacobmaxel@msn.com |
| Fax Number: | 847/776-7004 |

Additional Contact [Person who is also authorized to discuss the application for exemption permit]

| | |
|-------------------|------|
| Name: | none |
| Title: | |
| Company Name: | |
| Address: | |
| Telephone Number: | |
| E-mail Address: | |
| Fax Number: | |

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR EXEMPTION PERMIT
SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects.

Facility/Project Identification

| | | | |
|--------------------|--|---------------------|--------------------------------|
| Facility Name: | AMITA Health Alexian Brothers Medical Center | | |
| Street Address: | 800 Biesterfield Road | | |
| City and Zip Code: | Elk Grove Village, IL 60007 | | |
| County: | Cook | Health Service Area | VII Health Planning Area: A-07 |

Applicant(s) [Provide for each applicant (refer to Part 1130.220)]

| | |
|-------------------------------------|-----------------------------------|
| Exact Legal Name: | Alexian Brothers Health System |
| Street Address: | 3040 West Salt Creek Road |
| City and Zip Code: | Arlington Heights, IL 60005 |
| Name of Registered Agent: | C T Corporation System |
| Registered Agent Street Address: | 208 S. La Salle Street, Suite 814 |
| Registered Agent City and Zip Code: | Chicago, IL 60604 |
| Name of Chief Executive Officer: | Mark A. Frey |
| CEO Street Address: | 3040 West Salt Creek Road |
| CEO City and Zip Code: | Arlington Heights, IL 60005 |
| CEO Telephone Number: | 847/815-5100 |

Type of Ownership of Applicants

| | |
|--|---|
| <input checked="" type="checkbox"/> Non-profit Corporation | <input type="checkbox"/> Partnership |
| <input type="checkbox"/> For-profit Corporation | <input type="checkbox"/> Governmental |
| <input type="checkbox"/> Limited Liability Company | <input type="checkbox"/> Sole Proprietorship <input type="checkbox"/> Other |

- o Corporations and limited liability companies must provide an **Illinois certificate of good standing**.
- o Partnerships must provide the name of the state in which they are organized and the name and address of each partner specifying whether each is a general or limited partner.

APPEND DOCUMENTATION AS ATTACHMENT 1 IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Primary Contact [Person to receive ALL correspondence or inquiries]

| | |
|-------------------|---|
| Name: | Jacob M. Axel |
| Title: | President |
| Company Name: | Axel & Associates, Inc. |
| Address: | 675 North Court, Suite 210 Palatine, IL 60067 |
| Telephone Number: | 847/776-7101 |
| E-mail Address: | jacobmaxel@msn.com |
| Fax Number: | 847/776-7004 |

Additional Contact [Person who is also authorized to discuss the application for exemption permit]

| | |
|-------------------|------|
| Name: | none |
| Title: | |
| Company Name: | |
| Address: | |
| Telephone Number: | |
| E-mail Address: | |
| Fax Number: | |

Post Exemption Permit Contact

[Person to receive all correspondence subsequent to permit issuance-THIS PERSON MUST BE EMPLOYED BY THE LICENSED HEALTH CARE FACILITY AS DEFINED AT 20 ILCS 3960]

| | |
|-------------------|--|
| Name: | John Werrbach |
| Title: | CEO |
| Company Name: | AMITA Health Alexian Brothers Medical Center |
| Address: | 800 Biesterfield Road Elk Grove Village, IL 600007 |
| Telephone Number: | 847/437/5500 |
| E-mail Address: | john.werrbach@amitahealth.org |
| Fax Number: | |

Site Ownership

[Provide this information for each applicable site]

| | |
|---|--|
| Exact Legal Name of Site Owner: | Alexian Brothers Medical Center |
| Address of Site Owner: | 800 Biesterfield Road Elk Grove Village, IL 600007 |
| Street Address or Legal Description of the Site: | 800 Biesterfield Road Elk Grove Village, IL 600007 |
| Proof of ownership or control of the site is to be provided as Attachment 2. Examples of proof of ownership are property tax statements, tax assessor's documentation, deed, notarized statement of the corporation attesting to ownership, an option to lease, a letter of intent to lease, or a lease. | |
| APPEND DOCUMENTATION AS ATTACHMENT 2, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM. | |

Operating Identity/Licensee

[Provide this information for each applicable facility and insert after this page.]

| | | | |
|--|--|--------------------------------|--|
| Exact Legal Name: | AMITA Health Alexian Brothers Medical Center | | |
| Address: | 800 Biesterfield Road Elk Grove Village, IL 600007 | | |
| <input checked="checked" type="checkbox"/> Non-profit Corporation | <input type="checkbox"/> Partnership | | |
| <input type="checkbox"/> For-profit Corporation | <input type="checkbox"/> Governmental | | |
| <input type="checkbox"/> Limited Liability Company | <input type="checkbox"/> Sole Proprietorship | <input type="checkbox"/> Other | |
| <ul style="list-style-type: none">o Corporations and limited liability companies must provide an Illinois Certificate of Good Standing.o Partnerships must provide the name of the state in which organized and the name and address of each partner specifying whether each is a general or limited partner.o Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership. | | | |
| APPEND DOCUMENTATION AS ATTACHMENT 3, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM. | | | |

Organizational Relationships

Provide (for each applicant) an organizational chart containing the name and relationship of any person or entity who is related (as defined in Part 1130.140). If the related person or entity is participating in the development or funding of the project, describe the interest and the amount and type of any financial contribution.

APPEND DOCUMENTATION AS ATTACHMENT 4, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Flood Plain Requirements

[Refer to application instructions.]

Provide documentation that the project complies with the requirements of Illinois Executive Order #2006-5 pertaining to construction activities in special flood hazard areas. As part of the flood plain requirements, please provide a map of the proposed project location showing any identified floodplain areas. Floodplain maps can be printed at www.FEMA.gov or www.illinoisfloodmaps.org. **This map must be in a readable format.** In addition, please provide a statement attesting that the project complies with the requirements of Illinois Executive Order #2006-5 ([http:// www.illinois.gov/sites/hfsrb](http://www.illinois.gov/sites/hfsrb)).

APPEND DOCUMENTATION AS ATTACHMENT 5, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Historic Resources Preservation Act Requirements

[Refer to application instructions.]

Provide documentation regarding compliance with the requirements of the Historic Resources Preservation Act.

APPEND DOCUMENTATION AS ATTACHMENT 6, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

DESCRIPTION OF PROJECT

1. Project Classification

[Check those applicable - refer to Part 1110.40 and Part 1120.20(b)]

Part 1110 Classification:

- ☐ Change of Ownership
- ☒ Discontinuation of an Existing Health Care Facility or of a category of service
- ☐ Establishment or expansion of a neonatal intensive care or beds

2. Narrative Description

In the space below, provide a brief narrative description of the project. Explain **WHAT** is to be done in **State Board defined terms**, **NOT WHY** it is being done. If the project site does **NOT** have a street address, include a legal description of the site. Include the rationale regarding the project's classification as substantive or non-substantive.

The applicants, shortly following the approval of this Certificate of Exemption application, will discontinue AMITA Health Alexian Brothers Medical Center's ("ABMC's") 16-bed inpatient pediatrics service. The unit's average daily census in 2016 was 3.4 patients, and year-to-date utilization is tracking below last year. The hospital will continue to treat pediatric patients through the Emergency Department, a variety of outpatient services that will treat pediatric patients, and via network of pediatricians and family physicians officed on ABMC's campus.

AMITA Health has focused its pediatric care in the northwest suburbs on the AMITA Health St. Alexius Medical Center campus, located less than ten miles to the west of ABMC. That campus provides a wide array of inpatient and outpatient pediatrics services, including a pediatric Emergency Department, a 17-bed pediatrics unit, a pediatric ICU, inpatient and outpatient pediatric psychiatry programs and over sixty pediatric specialists, many of whom also have offices at ABMC.

The proposed project is limited to the discontinuation of ABMC's inpatient pediatric program, and no other services will be impacted.

The proposed discontinuation qualifies for consideration by the IHFSRB as a Certificate of Exemption, consistent with the provisions of Section 1130.410.b.

Project Costs and Sources of Funds (Neonatal Intensive Care Services only)

Complete the following table listing all costs (refer to Part 1120.110) associated with the project. When a project or any component of a project is to be accomplished by lease, donation, gift, or other means, the fair market or dollar value (refer to Part 1130.140) of the component must be included in the estimated project cost. If the project contains non-reviewable components that are not related to the provision of health care, complete the second column of the table below. Note, the use and sources of funds must be equal.

| Project Costs and Sources of Funds | | | |
|--|----------|-------------|-------|
| USE OF FUNDS | CLINICAL | NONCLINICAL | TOTAL |
| Preplanning Costs | | | |
| Site Survey and Soil Investigation | | | |
| Site Preparation | | | |
| Off Site Work | | | |
| New Construction Contracts | | | |
| Modernization Contracts | | | |
| Contingencies | | | |
| Architectural/Engineering Fees | | | |
| Consulting and Other Fees | | | |
| Movable or Other Equipment (not in construction contracts) | | | |
| Bond Issuance Expense (project related) | | | |
| Net Interest Expense During Construction (project related) | | | |
| Fair Market Value of Leased Space or Equipment | | | |
| Other Costs To Be Capitalized | | | |
| Acquisition of Building or Other Property (excluding land) | \$0 | \$0 | \$0 |
| TOTAL USES OF FUNDS | | | |
| SOURCE OF FUNDS | CLINICAL | NONCLINICAL | TOTAL |
| Cash and Securities | | | |
| Pledges | | | |
| Gifts and Bequests | | | |
| Bond Issues (project related) | | | |
| Mortgages | | | |
| Leases (fair market value) | | | |
| Governmental Appropriations | | | |
| Grants | | | |
| Other Funds and Sources | | | |
| TOTAL SOURCES OF FUNDS | \$0 | \$0 | \$0 |
| NOTE: ITEMIZATION OF EACH LINE ITEM MUST BE PROVIDED AT ATTACHMENT 7, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM. | | | |

5

Related Project Costs

Provide the following information, as applicable, with respect to any land related to the project that will be or has been acquired during the last two calendar years:

Land acquisition is related to project ☐ Yes ☒ No
Purchase Price: \$ _____
Fair Market Value: \$ _____

The project involves the establishment of a new facility or a new category of service
☐ Yes ☒ No

If yes, provide the dollar amount of all **non-capitalized** operating start-up costs (including operating deficits through the first full fiscal year when the project achieves or exceeds the target utilization specified in Part 1100.

Estimated start-up costs and operating deficit cost is \$ _____.

Project Status and Completion Schedules

For facilities in which prior permits have been issued please provide the permit numbers.

Indicate the stage of the project's architectural drawings:

☒ None or not applicable ☐ Preliminary
☐ Schematics ☐ Final Working

Anticipated project completion date (refer to Part 1130.140): February 1, 2018

Indicate the following with respect to project expenditures or to financial commitments (refer to Part 1130.140):

Not Applicable

Purchase orders, leases or contracts pertaining to the project have been executed.

☐ Financial commitment is contingent upon permit issuance. Provide a copy of the contingent "certification of financial commitment" document, highlighting any language related to CON Contingencies
☐ Financial Commitment will occur after permit issuance.

APPEND DOCUMENTATION AS ATTACHMENT 8, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

State Agency Submittals [Section 1130.620(c)]

Are the following submittals up to date as applicable:

☒ Cancer Registry

☒ APORS

☒ All formal document requests such as IDPH Questionnaires and Annual Bed Reports been submitted

☒ All reports regarding outstanding permits

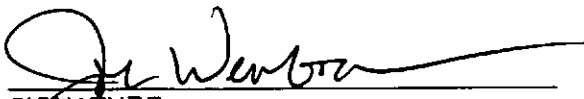
Failure to be up to date with these requirements will result in the application for permit being deemed incomplete.

CERTIFICATION

The Application must be signed by the authorized representatives of the applicant entity. Authorized representatives are:

- o in the case of a corporation, any two of its officers or members of its Board of Directors;
- o in the case of a limited liability company, any two of its managers or members (or the sole manager or member when two or more managers or members do not exist);
- o in the case of a partnership, two of its general partners (or the sole general partner, when two or more general partners do not exist);
- o in the case of estates and trusts, two of its beneficiaries (or the sole beneficiary when two or more beneficiaries do not exist); and
- o in the case of a sole proprietor, the individual that is the proprietor.

This Application is filed on the behalf of Alexian Brothers Medical Center d/b/a AMITA Alexian Health Alexian Brothers Medical Center * in accordance with the requirements and procedures of the Illinois Health Facilities Planning Act. The undersigned certifies that he or she has the authority to execute and file this Application on behalf of the applicant entity. The undersigned further certifies that the data and information provided herein, and appended hereto, are complete and correct to the best of his or her knowledge and belief. The undersigned also certifies that the fee required for this application is sent herewith or will be paid upon request.


SIGNATURE

JOHN WERBACH
PRINTED NAME

PRESIDENT/CEO
PRINTED TITLE


SIGNATURE

DONNA GAUTHIER
PRINTED NAME

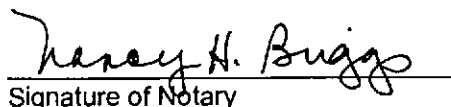
ASSISTANT SECRETARY
PRINTED TITLE

Notarization:

Subscribed and sworn to before me
this 20th day of November, 2017

Notarization:

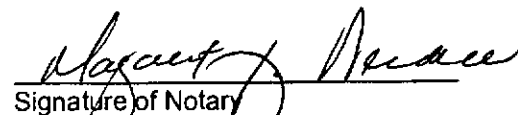
Subscribed and sworn to before me
this 11 day of December, 2017


Signature of Notary

Seal



*Insert the EXACT legal name of the applicant


Signature of Notary

Seal



CERTIFICATION

The Application must be signed by the authorized representatives of the applicant entity. Authorized representatives are:

- o in the case of a corporation, any two of its officers or members of its Board of Directors;
- o in the case of a limited liability company, any two of its managers or members (or the sole manager or member when two or more managers or members do not exist);
- o in the case of a partnership, two of its general partners (or the sole general partner, when two or more general partners do not exist);
- o in the case of estates and trusts, two of its beneficiaries (or the sole beneficiary when two or more beneficiaries do not exist); and
- o in the case of a sole proprietor, the individual that is the proprietor.

This Application is filed on the behalf of Ascension Health in accordance with the requirements and procedures of the Illinois Health Facilities Planning Act. The undersigned certifies that he or she has the authority to execute and file this Application on behalf of the applicant entity. The undersigned further certifies that the data and information provided herein, and appended hereto, are complete and correct to the best of his or her knowledge and belief. The undersigned also certifies that the fee required for this application is sent herewith or will be paid upon request.

Christine McCoy
SIGNATURE

Christine McCoy
PRINTED NAME

Assistant Secretary
PRINTED TITLE

Rhonda Anderson
SIGNATURE

Rhonda Anderson
PRINTED NAME

Assistant Treasurer
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 10th day of November, 2017

Notarization:
Subscribed and sworn to before me
this 10th day of NOVEMBER, 2017

Elfriede M. Rohe
Signature of Notary

Seal

ELFRIEDE M. ROHE
Notary Public - Notary Seal
STATE OF MISSOURI
Comm. Number 01505902
St. Louis County
My Commission Expires: July 13, 2020

Patricia D. Chitwood
Signature of Notary

Seal

PATRICIA D. CHITWOOD
Notary Public - Notary Seal
State of Missouri, St. Louis County
Commission Number 12383265
My Commission Expires Aug 15, 2020

*Insert the EXACT legal name of the applicant

CERTIFICATION

The Application must be signed by the authorized representatives of the applicant entity. Authorized representatives are:

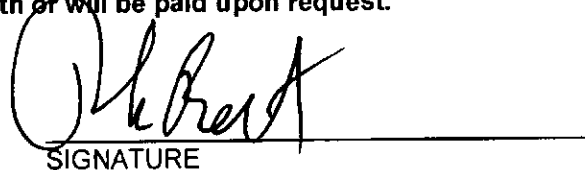
- o in the case of a corporation, any two of its officers or members of its Board of Directors;
- o in the case of a limited liability company, any two of its managers or members (or the sole manager or member when two or more managers or members do not exist);
- o in the case of a partnership, two of its general partners (or the sole general partner, when two or more general partners do not exist);
- o in the case of estates and trusts, two of its beneficiaries (or the sole beneficiary when two or more beneficiaries do not exist); and
- o in the case of a sole proprietor, the individual that is the proprietor.

This Application is filed on the behalf of Alexian Brothers-AHS Midwest Region Health Co. d/b/a AMITA Health * in accordance with the requirements and procedures of the Illinois Health Facilities Planning Act. The undersigned certifies that he or she has the authority to execute and file this Application on behalf of the applicant entity. The undersigned further certifies that the data and information provided herein, and appended hereto, are complete and correct to the best of his or her knowledge and belief. The undersigned also certifies that the fee required for this application is sent herewith or will be paid upon request.


SIGNATURE

MARK A. FREY
PRINTED NAME

PRESIDENT / CEO
PRINTED TITLE


SIGNATURE

PAUL E. BELTER
PRINTED NAME

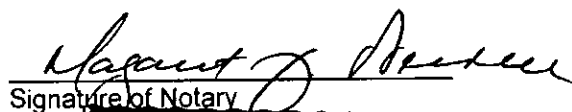
SVP / CFO
PRINTED TITLE

Notarization:

Subscribed and sworn to before me
this 11 day of December 2017

Notarization:

Subscribed and sworn to before me
this 11 day of December 2017

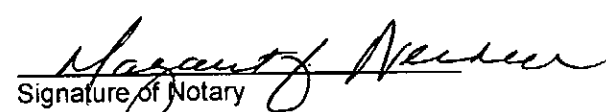

Signature of Notary

Seal



MARGARET J. WENDELL
OFFICIAL SEAL
Notary Public, State of Illinois
My Commission Expires
September 05, 2018

*Insert the EXACT legal name of the applicant


Signature of Notary

Seal



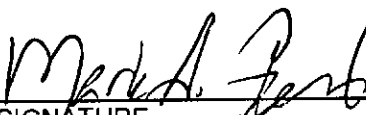
MARGARET J. WENDELL
OFFICIAL SEAL
Notary Public, State of Illinois
My Commission Expires
September 05, 2018

CERTIFICATION

The Application must be signed by the authorized representatives of the applicant entity. Authorized representatives are:

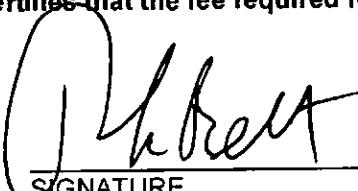
- in the case of a corporation, any two of its officers or members of its Board of Directors;
- in the case of a limited liability company, any two of its managers or members (or the sole manager or member when two or more managers or members do not exist);
- in the case of a partnership, two of its general partners (or the sole general partner, when two or more general partners do not exist);
- in the case of estates and trusts, two of its beneficiaries (or the sole beneficiary when two or more beneficiaries do not exist); and
- in the case of a sole proprietor, the individual that is the proprietor.

This Application is filed on the behalf of Alexian Brothers Health System *
in accordance with the requirements and procedures of the Illinois Health Facilities Planning Act. The undersigned certifies that he or she has the authority to execute and file this Application on behalf of the applicant entity. The undersigned further certifies that the data and information provided herein, and appended hereto, are complete and correct to the best of his or her knowledge and belief. The undersigned also certifies that the fee required for this application is sent herewith or will be paid upon request.


SIGNATURE

MARK A. FREY
PRINTED NAME

PRESIDENT / CEO
PRINTED TITLE

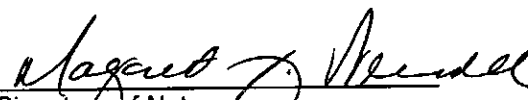

SIGNATURE

PAUL E. BELTER
PRINTED NAME

SVP / CFO
PRINTED TITLE

Notarization:

Subscribed and sworn to before me
this 11th day of December 2017


Signature of Notary

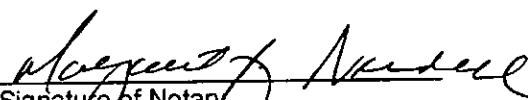
Seal



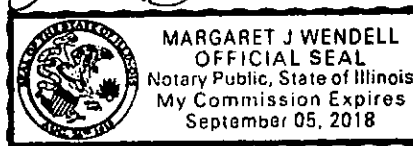
*Insert the EXACT legal name of the applicant

Notarization:

Subscribed and sworn to before me
this 11th day of December 2017


Signature of Notary

Seal



SECTION II. DISCONTINUATION

This Section is applicable to the discontinuation of a health care facility maintained by a State agency. **NOTE:** If the project is solely for discontinuation and if there is no project cost, the remaining Sections of the application are not applicable.

Type of Discontinuation

Discontinuation of an Existing Health Care Facility

X

Discontinuation of a category of service

Criterion 1110.130 - Discontinuation

READ THE REVIEW CRITERION and provide the following information:

GENERAL INFORMATION REQUIREMENTS

1. Identify the categories of service and the number of beds, if any, that are to be discontinued.
2. Identify all of the other clinical services that are to be discontinued.
3. Provide the anticipated date of discontinuation for each identified service or for the entire facility.
4. Provide the anticipated use of the physical plant and equipment after the discontinuation occurs.
5. Provide the anticipated disposition and location of all medical records pertaining to the services being discontinued, and the length of time the records will be maintained.
6. For applications involving the discontinuation of an entire facility, provide certification by an authorized representative that all questionnaires and data required by HFSRB or DPH (e.g., annual questionnaires, capital expenditures surveys, etc.) will be provided through the date of discontinuation, and that the required information will be submitted no later than 90 days following the date of discontinuation.
7. Upon a finding that an application to close a health care facility is complete, the State Board shall publish a legal notice on 3 consecutive days in a newspaper of general circulation in the area or community to be affected and afford the public an opportunity to request a hearing. If the application is for a facility located in a Metropolitan Statistical Area, an additional legal notice shall be published in a newspaper of limited circulation, if one exists, in the area in which the facility is located. If the newspaper of limited circulation is published on a daily basis, the additional legal notice shall be published on 3 consecutive days. The legal notice shall also be posted on the Health Facilities and Services Review Board's web site and sent to the State Representative and State Senator of the district in which the health care facility is located. In addition, the health care facility shall provide notice of closure to the local media that the health care facility would routinely notify about facility events.
8. Provide attestation that the facility provided the required notice of the facility or category of service closure to local media that the health care facility would routinely notify about facility events. The supporting documentation shall include a copy of the notice, the name of the local media outlet, the date the notice was given, and the result of the notice, e.g., number of times broadcasted, written, or published. Only notice that is given to a local television station, local radio station, or local newspaper will be accepted.

REASONS FOR DISCONTINUATION

The applicant shall state the reasons for the discontinuation and provide data that verifies the need for the proposed action. See criterion 1110.130(b) for examples.

IMPACT ON ACCESS

1. Document that the discontinuation of each service or of the entire facility and whether or not it will have an adverse effect upon access to care for residents of the facility's market area.
2. Document that a written request for an impact statement was received by all existing or approved health care facilities (that provide the same services as those being discontinued) located within 45 minutes travel time of the applicant facility.

APPEND DOCUMENTATION AS ATTACHMENT 10, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION III. BACKGROUND, PURPOSE OF THE PROJECT, AND ALTERNATIVES
- INFORMATION REQUIREMENTS

Not Applicable

This Section is applicable to all projects except those that are solely for discontinuation with no project costs.

Background

READ THE REVIEW CRITERION and provide the following required information:

BACKGROUND OF APPLICANT

1. A listing of all health care facilities owned or operated by the applicant, including licensing, and certification if applicable.
2. A certified listing of any adverse action taken against any facility owned and/or operated by the applicant during the three years prior to the filing of the application.
3. Authorization permitting HFSRB and DPH access to any documents necessary to verify the information submitted, including, but not limited to: official records of DPH or other State agencies; the licensing or certification records of other states, when applicable; and the records of nationally recognized accreditation organizations. **Failure to provide such authorization shall constitute an abandonment or withdrawal of the application without any further action by HFSRB.**
4. If, during a given calendar year, an applicant submits more than one application for permit, the documentation provided with the prior applications may be utilized to fulfill the information requirements of this criterion. In such instances, the applicant shall attest that the information was previously provided, cite the project number of the prior application, and certify that no changes have occurred regarding the information that has been previously provided. The applicant is able to submit amendments to previously submitted information, as needed, to update and/or clarify data.

APPEND DOCUMENTATION AS ATTACHMENT 11, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM. EACH ITEM (1-4) MUST BE IDENTIFIED IN ATTACHMENT 11.

Criterion 1110.230 – Purpose of the Project, and Alternatives (Not applicable to Change of Ownership)

PURPOSE OF PROJECT

1. Document that the project will provide health services that improve the health care or well-being of the market area population to be served.
2. Define the planning area or market area, or other relevant area, per the applicant's definition.
3. Identify the existing problems or issues that need to be addressed as applicable and appropriate for the project.
4. Cite the sources of the documentation.
5. Detail how the project will address or improve the previously referenced issues, as well as the population's health status and well-being.
6. Provide goals with quantified and measurable objectives, with specific timeframes that relate to achieving the stated goals **as appropriate**.

For projects involving modernization, describe the conditions being upgraded, if any. For facility projects, include statements of the age and condition of the project site, as well as regulatory citations, if any. For equipment being replaced, include repair and maintenance records.

NOTE: Information regarding the "Purpose of the Project" will be included in the State Board Report.

APPEND DOCUMENTATION AS ATTACHMENT 12, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM. EACH ITEM (1-6) MUST BE IDENTIFIED IN ATTACHMENT 12.

ALTERNATIVES

- 1) Identify **ALL** of the alternatives to the proposed project:

Alternative options **must** include:

- A) Proposing a project of greater or lesser scope and cost;
- B) Pursuing a joint venture or similar arrangement with one or more providers or entities to meet all or a portion of the project's intended purposes; developing alternative settings to meet all or a portion of the project's intended purposes;
- C) Utilizing other health care resources that are available to serve all or a portion of the population proposed to be served by the project; and
- D) Provide the reasons why the chosen alternative was selected.

- 2) Documentation shall consist of a comparison of the project to alternative options. The comparison shall address issues of total costs, patient access, quality and financial benefits in both the short-term (within one to three years after project completion) and long-term. This may vary by project or situation. **FOR EVERY ALTERNATIVE IDENTIFIED, THE TOTAL PROJECT COST AND THE REASONS WHY THE ALTERNATIVE WAS REJECTED MUST BE PROVIDED.**

- 3) The applicant shall provide empirical evidence, including quantified outcome data that verifies improved quality of care, as available.

APPEND DOCUMENTATION AS ATTACHMENT 13, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION VII. 1120.130 - FINANCIAL VIABILITY

Not Applicable

All the applicants and co-applicants shall be identified, specifying their roles in the project funding or guaranteeing the funding (sole responsibility or shared) and percentage of participation in that funding.

Financial Viability Waiver

The applicant is not required to submit financial viability ratios if:

1. "A" Bond rating or better
2. All of the projects capital expenditures are completely funded through internal sources
3. The applicant's current debt financing or projected debt financing is insured or anticipated to be insured by MBIA (Municipal Bond Insurance Association Inc.) or equivalent
4. The applicant provides a third party surety bond or performance bond letter of credit from an A rated guarantor.

See Section 1120.130 Financial Waiver for information to be provided

APPEND DOCUMENTATION AS ATTACHMENT 17, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

The applicant or co-applicant that is responsible for funding or guaranteeing funding of the project shall provide viability ratios for the latest three years for which **audited financial statements are available and for the first full fiscal year at target utilization, but no more than two years following project completion.** When the applicant's facility does not have facility specific financial statements and the facility is a member of a health care system that has combined or consolidated financial statements, the system's viability ratios shall be provided. If the health care system includes one or more hospitals, the system's viability ratios shall be evaluated for conformance with the applicable hospital standards.

| | Historical 3 Years | | | Projected |
|---|-------------------------------|--|--|------------------|
| Enter Historical and/or Projected Years: | | | | |
| Current Ratio | | | | |
| Net Margin Percentage | | | | |
| Percent Debt to Total Capitalization | | | | |
| Projected Debt Service Coverage | | | | |
| Days Cash on Hand | | | | |
| Cushion Ratio | | | | |

Provide the methodology and worksheets utilized in determining the ratios detailing the calculation and applicable line item amounts from the financial statements. Complete a separate table for each co-applicant and provide worksheets for each.

2. Variance

Applicants not in compliance with any of the viability ratios shall document that another organization, public or private, shall assume the legal responsibility to meet the debt obligations should the applicant default.

APPEND DOCUMENTATION AS ATTACHMENT 18, IN NUMERICAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION VIII. 1120.140 - ECONOMIC FEASIBILITY

This section is applicable to all projects subject to Part 1120.

Not Applicable

A. Reasonableness of Financing Arrangements

The applicant shall document the reasonableness of financing arrangements by submitting a notarized statement signed by an authorized representative that attests to one of the following:

- 1) That the total estimated project costs and related costs will be funded in total with cash and equivalents, including investment securities, unrestricted funds, received pledge receipts and funded depreciation; or
- 2) That the total estimated project costs and related costs will be funded in total or in part by borrowing because:
 - A) A portion or all of the cash and equivalents must be retained in the balance sheet asset accounts in order to maintain a current ratio of at least 2.0 times for hospitals and 1.5 times for all other facilities; or
 - B) Borrowing is less costly than the liquidation of existing investments, and the existing investments being retained may be converted to cash or used to retire debt within a 60-day period.

B. Conditions of Debt Financing

This criterion is applicable only to projects that involve debt financing. The applicant shall document that the conditions of debt financing are reasonable by submitting a notarized statement signed by an authorized representative that attests to the following, as applicable:

- 1) That the selected form of debt financing for the project will be at the lowest net cost available;
- 2) That the selected form of debt financing will not be at the lowest net cost available, but is more advantageous due to such terms as prepayment privileges, no required mortgage, access to additional indebtedness, term (years), financing costs and other factors;
- 3) That the project involves (in total or in part) the leasing of equipment or facilities and that the expenses incurred with leasing a facility or equipment are less costly than constructing a new facility or purchasing new equipment.

C. Reasonableness of Project and Related Costs

Read the criterion and provide the following:

1. Identify each department or area impacted by the proposed project and provide a cost and square footage allocation for new construction and/or modernization using the following format (insert after this page).

COST AND GROSS SQUARE FEET BY DEPARTMENT OR SERVICE

| Department (list below) | A | B | C | D | E | F | G | H | Total Cost (G + H) |
|----------------------------|-------------------------|------|--------------------------------|---|---------------------------------|---|----------------------|--------------------|--------------------------|
| | Cost/Square Foot New | Mod. | Gross Sq. Ft. New Circ.* | | Gross Sq. Ft. Mod. Circ.* | | Const. \$ (A x C) | Mod. \$ (B x E) | |
| | | | | | | | | | |
| Contingency | | | | | | | | | |
| TOTALS | | | | | | | | | |

* Include the percentage (%) of space for circulation

D. Projected Operating Costs

The applicant shall provide the projected direct annual operating costs (in current dollars per equivalent patient day or unit of service) for the first full fiscal year at target utilization but no more than two years following project completion. Direct cost means the fully allocated costs of salaries, benefits and supplies for the service.

E. Total Effect of the Project on Capital Costs

The applicant shall provide the total projected annual capital costs (in current dollars per equivalent patient day) for the first full fiscal year at target utilization but no more than two years following project completion.

APPEND DOCUMENTATION AS ATTACHMENT 19, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION IX. SAFETY NET IMPACT STATEMENT (DISCONTINUATION ONLY)

SAFETY NET IMPACT STATEMENT that describes all of the following must be submitted for ALL SUBSTANTIVE PROJECTS AND PROJECTS TO DISCONTINUE STATE-OWNED HEALTH CARE FACILITIES [20 ILCS 3960/5.4]:

1. The project's material impact, if any, on essential safety net services in the community, to the extent that it is feasible for an applicant to have such knowledge.
2. The project's impact on the ability of another provider or health care system to cross-subsidize safety net services, if reasonably known to the applicant.
3. How the discontinuation of a facility or service might impact the remaining safety net providers in a given community, if reasonably known by the applicant.

Safety Net Impact Statements shall also include all of the following:

1. For the 3 fiscal years prior to the application, a certification describing the amount of charity care provided by the applicant. The amount calculated by hospital applicants shall be in accordance with the reporting requirements for charity care reporting in the Illinois Community Benefits Act. Non-hospital applicants shall report charity care, at cost, in accordance with an appropriate methodology specified by the Board.
2. For the 3 fiscal years prior to the application, a certification of the amount of care provided to Medicaid patients. Hospital and non-hospital applicants shall provide Medicaid information in a manner consistent with the information reported each year to the Illinois Department of Public Health regarding "Inpatients and Outpatients Served by Payor Source" and "Inpatient and Outpatient Net Revenue by Payor Source" as required by the Board under Section 13 of this Act and published in the Annual Hospital Profile.
3. Any information the applicant believes is directly relevant to safety net services, including information regarding teaching, research, and any other service.

A table in the following format must be provided as part of Attachment 40.

AMITA Health Alexian Brothers Medical Center

| Safety Net Information per PA 96-0031 | | | |
|---------------------------------------|---------------------|---------------------|---------------------|
| CHARITY CARE | | | |
| Charity (# of patients) | 2014 | 2015 | 2016 |
| Inpatient | 408 | 311 | 125 |
| Outpatient | 3,419 | 3,008 | 1,477 |
| Total | 3,827 | 3,319 | 1,602 |
| Charity (cost in dollars) | | | |
| Inpatient | \$5,283,599 | \$2,531,000 | \$3,192,619 |
| Outpatient | \$4,196,401 | \$2,126,000 | \$1,973,431 |
| Total | \$9,480,000 | \$4,657,000 | \$5,166,050 |
| MEDICAID | | | |
| Medicaid (# of patients) | 2014 | 2015 | 2016 |
| Inpatient | 2,333 | 1,074 | 3,806 |
| Outpatient | 47,747 | 41,044 | 49,428 |
| Total | 50,080 | 42,118 | 53,234 |
| Medicaid (revenue) | | | |
| Inpatient | \$13,796,842 | \$13,668,000 | \$24,917,316 |
| Outpatient | \$8,415,357 | \$8,288,000 | \$14,100,420 |
| Total | \$22,212,199 | \$21,956,000 | \$39,017,736 |



To all to whom these Presents Shall Come, Greeting:

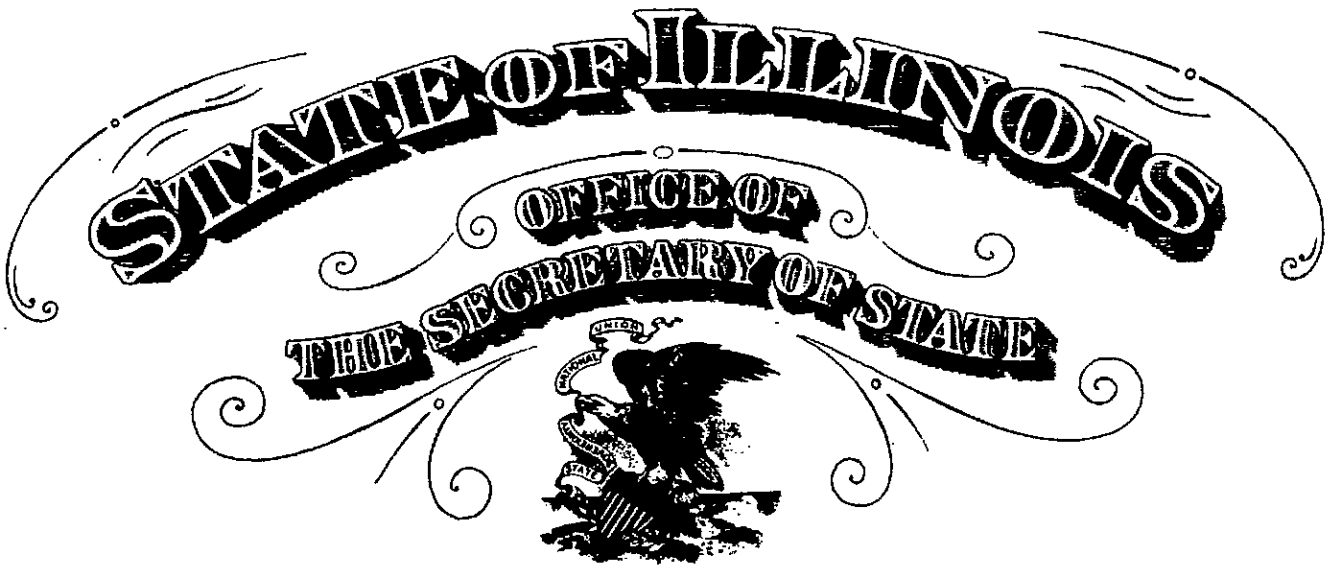
I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that I am the keeper of the records of the Department of Business Services. I certify that

ALEXIAN BROTHERS MEDICAL CENTER, INCORPORATED IN TEXAS AND LICENSED TO CONDUCT AFFAIRS IN THIS STATE ON AUGUST 02, 1971, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS A FOREIGN CORPORATION IN GOOD STANDING AND AUTHORIZED TO CONDUCT AFFAIRS IN THE STATE OF ILLINOIS.



***In Testimony Whereof, I hereto set
my hand and cause to be affixed the Great Seal of
the State of Illinois, this 30TH
day of OCTOBER A.D. 2017 .***

Jesse White



To all to whom these Presents Shall Come, Greeting:

I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that I am the keeper of the records of the Department of Business Services. I certify that

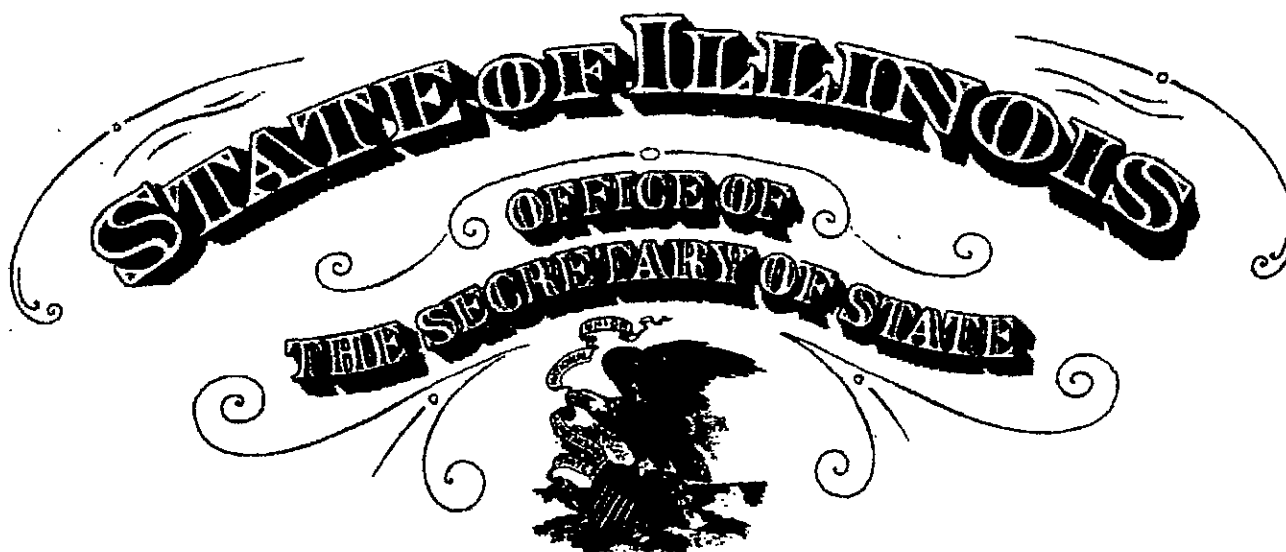
ALEXIAN BROTHERS HEALTH SYSTEM, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON OCTOBER 03, 1983, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.



***In Testimony Whereof, I hereto set
my hand and cause to be affixed the Great Seal of
the State of Illinois, this 20TH
day of NOVEMBER A.D. 2017 .***

Jesse White

SECRETARY OF STATE



To all to whom these Presents Shall Come, Greeting:

I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that I am the keeper of the records of the Department of Business Services. I certify that

ASCENSION HEALTH, INCORPORATED IN MISSOURI AND LICENSED TO CONDUCT AFFAIRS IN THIS STATE ON JUNE 27, 2011, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS A FOREIGN CORPORATION IN GOOD STANDING AND AUTHORIZED TO CONDUCT AFFAIRS IN THE STATE OF ILLINOIS.



In Testimony Whereof, I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this 31ST day of MARCH A.D. 2017 .

Jesse White

SECRETARY OF STATE ATTACHMENT 1



To all to whom these Presents Shall Come, Greeting:

I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that I am the keeper of the records of the Department of Business Services. I certify that

ALEXIAN BROTHERS-AHS MIDWEST REGION HEALTH CO., A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON SEPTEMBER 26, 2014, ADOPTED THE ASSUMED NAME AMITA HEALTH ON APRIL 14, 2015, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.

**In Testimony Whereof, I hereto set
my hand and cause to be affixed the Great Seal of
the State of Illinois, this 31ST
day of MARCH A.D. 2017 .**



Authentication #: 1709001842 verifiable until 03/31/2018
Authenticate at: <http://www.cyberdriveillinois.com>

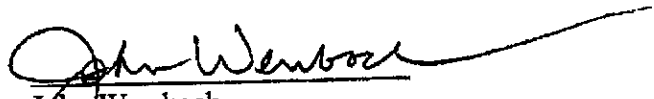
Jesse White

SECRETARY OF STATE

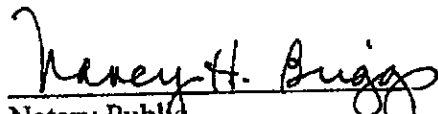
ATTACHMENT 1

SITE OWNERSHIP

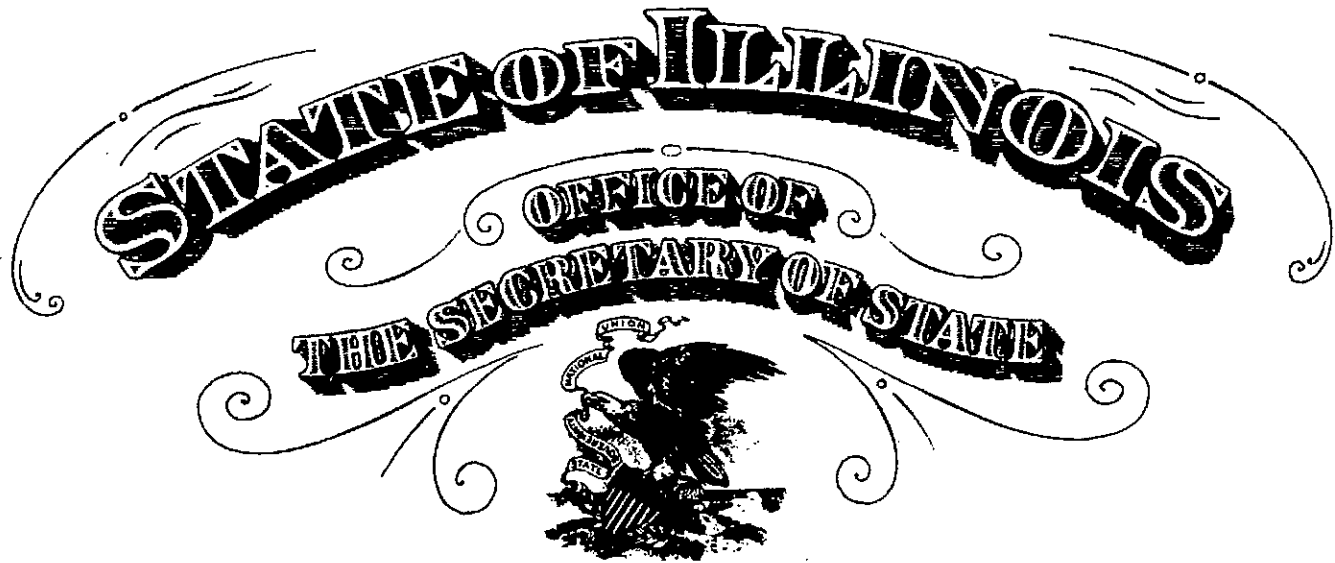
AMITA Health Alexian Brothers Medical Center's site is owned by Alexian Brothers Medical Center.


John Werrbach
Chief Executive Officer
AMITA Health Alexian Brothers Medical Center

Subscribed and sworn to me
This 20th day of November, 2017


Nancy H. Briggs
Notary Public





To all to whom these Presents Shall Come, Greeting:

I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that I am the keeper of the records of the Department of Business Services. I certify that

ALEXIAN BROTHERS MEDICAL CENTER, INCORPORATED IN TEXAS AND LICENSED TO CONDUCT AFFAIRS IN THIS STATE ON AUGUST 02, 1971, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS A FOREIGN CORPORATION IN GOOD STANDING AND AUTHORIZED TO CONDUCT AFFAIRS IN THE STATE OF ILLINOIS.

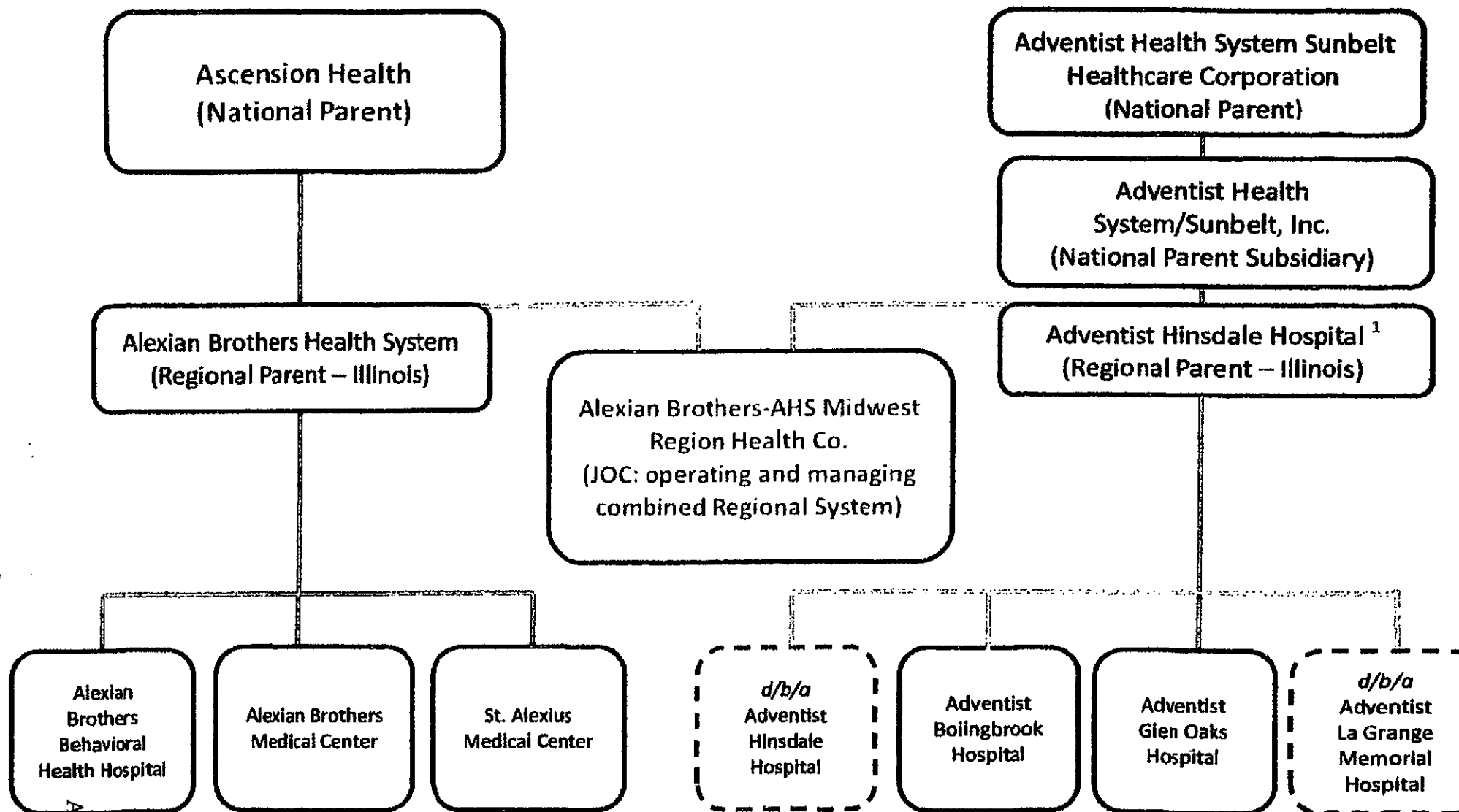


***In Testimony Whereof, I hereto set
my hand and cause to be affixed the Great Seal of
the State of Illinois, this 30TH
day of OCTOBER A.D. 2017 .***

Jesse White

SECRETARY OF STATE ATTACHMENT 3

Ascension - Adventist Joint Operating Company



Attachment 4

☐ = legal entity

☐ = operating division of legal entity

¹ Once regulatory approval is obtained, the legal entity "Adventist Hinsdale Hospital" will change its name to "Adventist Midwest Health" and will establish "Adventist Hinsdale Hospital" and "Adventist La Grange Memorial Hospital" as d/b/a's for the licensed health care facilities it operates.

DISCONTINUATION

General Information Requirements

1. AMITA Health Alexian Brothers Medical Center's ("ABMC's") inpatient pediatrics category of service, consisting of sixteen (16) beds will be discontinued.
2. No other clinical services will be discontinued as a result of the Certificate of Exemption ("COE") sought through this application.
3. ABMC has notified the IHFSRB of a "suspension" of the pediatric inpatient program, with the last patient being discharged on or about October 30, 2017. Discontinuation, in the form of filing proper documentation with the IHFSRB will occur within thirty days of the COE's approval.
4. A decision of the future use of the 16-bed nursing unit (5-West) has yet to be made. Among the potential uses under consideration is the conversion of the unit to a Medical/Surgical unit, which, if selected, would be done consistent with IHFSRB and IDPH requirements.
5. Medical records and other pertinent information relating to services provided to pediatrics inpatients will be retained by ABMC, consistent with its records retention and maintenance policies.
6. The proposed project is limited to the discontinuation of a single category of service, and therefore criterion 1110.130.a)6 is not applicable.

7. It is anticipated that the State Board will publish appropriate legal notices relating to the proposed discontinuation.
8. With the filing of this application, the applicants attest that the required notice of the anticipated category of service discontinuation was published on November 16, 2017 in the Elk Grove Journal and Topics newspaper (copy attached).

forwarding & warehousing regulations, fin1 records of import/export operations, negotiating w/ shipping co's, communicating w/ customers re shipping & delivery. Regs 2 yrs Import/Export exp & fluency in Chinese. Resumes to: M. Joe Impex GLS Inc, 840 N. Central Ave, #201, Wood Dale IL 60191

0240 Radio Time Sales

Now Hiring!!! Up to \$1500 w/ high commissions. 22B sales with qualified leads. Flexible Hrs & benefits. Fun work environment. No experience necessary. Call Tim at 224-944-2267 or nwjobs.com

0670 Miscellaneous For Sale

Huge All Must Car Sale Office Furn. Supplies, Equip. Golf Stuff, Books, Tools Key Mach. Fila Mkt. Stuff R/C Planes, Trans. Motors Must Call For Appt. & Loc. Paul 847-208-9595

0670 Books of Music

FREE clarinet, saxophone, flute and piano books of music. 847-824-3264

DRIVE A BARGAIN JOURNAL & TOPICS NEWSPAPERS

PLAINES, IL 60116. The true and real full names and residence address of the owner(s)/partner(s) is ARVIND PATEL, 800 EAST NORTHWEST HIGHWAY STE 200, DGS, PLAINES, IL US 60116

0900 Legals

AMITA Health Alexan Brothers Medical Center in Elk Grove Village intends to close its 16-bed inpatient pediatrics unit following approval to do so is issued by the Illinois Health Facilities and Services Review Board ("IHFSRB"). The discontinuation will occur prior to February 1, 2018. The medical center intends to file the required Certificate of Exemption application by December 10, 2017, and it, as well as information concerning the proposed discontinuation can be found on the IHFSRB website at: hfsrb.illinois.gov

SNAP UP EXTRA CASH WITH AN AD IN THE CLASSIFIEDS

Your ad in the Classifieds puts the bite on the right buyer for most anything you have to sell. Call today and our friendly ad takers will help you put some real teeth into your message. (847) 208-5511 Journal & Topics Newspapers

firm and multiple con- sidered to a prac- any project approach prosecution and refile do contract documents.

Plans, specifications, and a statement of quali- Consultants, Inc., 651 We Mr. Larry Thomas at 10141 Morton Grove Niles, IL schedule, submittal, require MGNWC Superintendent W C/O Village of Niles, 1100 C

Any contract or con- qualifications are ex- Environmental Prote- of its departments, a and proposals of any res- contained in the Proc- Program, 3511AC P- 65 defined by the United State on Public Works Act, 111.0 This procurement is also an affirmative efforts at least a policy is contained in the up with the President's 1. reall respondents and con- factor

0900 Legals

No notice

THE MORTON GROVE TO SELL NOT TO EXCEED \$111

Public Notice is Here / ON County, Illinois (the 7th of November 2017) at 2:00 PM Hall, located at 1000 JWC will be to receive put 2.000 in the amount of not less than acquiring, construction and waterworks system in the residents, business owners, properties within the Village. By order of the Chairman of Water Commission, (Book C) Dated the 31st day of Octob

John Plehn, Clerk, Morton Grove

Reason for Discontinuation

The primary reason for the proposed discontinuation of inpatient pediatrics services at ABMC is the low census. Between 2013 and 2016, the annual average daily census ("ADC") on ABMC's 16-bed pediatrics unit ranged from 3.0 to 3.4 patients. The census dropped further in 2017, with the January-October ADC being only 2.3 patients (Monthly high of 3.9 patients and monthly low of 1.0 patient.). Such a low census level results in difficulties in recruiting personnel with a desire to work with a pediatric population, difficulties in staff's ability to maintain proficiencies, and difficulties in operating a unit in an efficient manner.

Two trends have emerged during the past decade that are consistent with ABMC's experience. First, there is a greater reliance—particularly in the area of pediatric surgery—on outpatient care, as opposed to inpatient care. Second, inpatient pediatric care is being centralized in a limited number of hospitals, able to provide the required expertise as a result of a substantial patient census. In the case of AMITA Health, a decision has been made to invest capital in the development of pediatric programming on the AMITA Health St. Alexius Medical Center campus, located less than ten miles from ABMC.

Impact on Access

The proposed discontinuation of inpatient pediatric services at ABMC will have no substantial impact on the ability of residents of the hospital's service area to access care.

Currently, there are nineteen providers of inpatient pediatric care within 45 minutes travel time (per MapQuest, adjusted 10/26/2017 2:15-2:40PM) of ABMC. Those hospitals are listed below: Presence Resurrection Medical Center, Chicago

- Shriners Hospital for Children, Chicago
- Swedish Covenant Hospital, Chicago
- AMITA Adventist Hinsdale Hospital, Hinsdale
- Northwestern Medicine Central DuPage Hospital, Winfield
- Edward Hospital, Naperville
- Elmhurst Memorial Hospital
- Advocate Good Samaritan Hospital, Downers Grove
- Loyola Health System at Gottlieb, Melrose Park
- Loyola University Medical Center, Maywood
- West Suburban Medical Center, Oak Park
- Westlake Hospital, Melrose Park
- Advocate Lutheran General Hospital, Park Ridge
- Northwest Community Hospital, Arlington Heights
- AMITA St. Alexius Medical Center, Hoffman Estates
- Advocate Condell Medical Center, Libertyville
- Advocate Good Shepherd Hospital, Barrington
- Highland Park Hospital, Highland Park
- Advocate Sherman Hospital, Elgin

Letters, consistent with the requirements of Section 1110.130.c were sent to each of the hospitals listed above on November 27, 2017. No responses were received.

Confirmations of receipt are attached.

by Certified Mail
Delivery Receipt Requested

October 26, 2017

RE: Proposed Discontinuation of Inpatient
Pediatrics Service at AMITA Alexian
Brothers Medical Center

Dear :

AMITA Health Alexian Brothers Medical Center intends to file a Certificate of Exemption ("COE") application with the Illinois Health Facilities and Services Review Board ("IHFSRB"), addressing the discontinuation of the hospital's inpatient pediatrics unit. The hospital will continue to operate a variety of pediatric outpatient programs.

Through this letter and consistent with the provisions of Section 1110.130, you are requested, should you elect to do so, to provide an impact statement, consistent with the identified requested information contained in the above-referenced section; including: 1) whether your hospital has or will have available capacity to accommodate a portion or all of AMITA Health Alexian Brothers Medical Center's experienced caseload, and 2) whether any restrictions or limitations preclude providing service to residents of AMITA Health Alexian Brothers Medical Center's service area.

The anticipated date for discontinuation is approximately December 31, 2017.

During the 24-month period ending December 31, 2016, a total of 302 children were admitted to AMITA Health Alexian Brothers Medical Center's inpatient pediatrics unit.

A copy of any response to this request received within fifteen days of your receipt of this letter will be forwarded to the IHFSRB.

Sincerely,

John Werrbach
Chief Executive Officer

ATTACHMENT 10

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Northwest Community Hospital
 Stephen Scogna, President/CEO
 800 West Central Road
 Arlington Heights, IL 60005-2392

COMPLETE THIS SECTION ON DELIVERY

A. Signature

X

☐ Agent☐ Addressee

B. Received by (Printed Name)

C. Date of Delivery

D. Is delivery address different from item 1? ☐ Yes

If YES, enter delivery address below:

☐ No

3. Service Type

☒ Certified Mail☐ Express Mail☐ Registered☐ Return Receipt for Merchandise☐ Insured Mail☐ C.O.D.

4. Restricted Delivery? (Extra Fee)

☐ Yes

7001 1140 0001 6034 5968

PS Form 3811, February 2004

Domestic Return Receipt

102595-02-M-1540

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

AMITA Health St. Alexius Medical
 Center
 Len Wilk, President/CEO
 1555 Barrington Road
 Hoffman Estates, IL 60169

COMPLETE THIS SECTION ON DELIVERY

A. Signature

X

☒ Agent☐ Addressee

B. Received by (Printed Name)

C. Date of Delivery

D. Is delivery address different from item 1? ☐ Yes

If YES, enter delivery address below:

☒ No

3. Service Type

☐ Certified Mail☐ Express Mail☐ Registered☐ Return Receipt for Merchandise☐ Insured Mail☐ C.O.D.

4. Restricted Delivery? (Extra Fee)

☐ Yes

7014 0510 0000 1510 3684

PS Form 3811, February 2004

Domestic Return Receipt

102595-02-M-1540

ATTACHMENT 10

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Advocate Sherman Hospital
Richard Floyd, President
1425 North Randall Road
Elgin, IL 60123-2300

2. Article Number

(Transfer from service label)

PS Form 3811, February 2004

Domestic Return Receipt

102595-02-M-1540

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Gottlieb Memorial Hospital
Ken Fishbain, CEO
701 West North Avenue
Melrose Park, IL 60160-1612

COMPLETE THIS SECTION ON DELIVERY

A. Signature

X *Richard Floyd*☒ Agent☐ Addressee

B. Received by (Printed Name)

Richard Floyd

C. Date of Delivery

*11-14-17*D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☒ No

3. Service Type

☒ Certified Mail☐ Express Mail☐ Registered☐ Return Receipt for Merchandise☐ Insured Mail☐ C.O.D.

4. Restricted Delivery? (Extra Fee)

☐ Yes

7001 1140 0001 6034 5913

PS Form 3811, February 2004

Domestic Return Receipt

102595-02-M-1540

SENDER: COMPLETE THIS SECTION

1. Complete items 1, 2, and 3.

- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

AMITA Health Adventist Medical
Center, Bolingbrook
Bruce Christian, President/CEO
500 Remington Blvd.
Bolingbrook, IL 60440



9590 9403 0564 5173 9819 96

2. Article Number (Transfer from service label)

7005 3110 0003 2673 1665

PS Form 3811, April 2015 PSN 7530-02-000-9053

Domestic Return Receipt

COMPLETE THIS SECTION ON DELIVERY

A. Signature

X *[Signature]*

☒ Agent

☐ Addressee

B. Received by (Printed Name)

A. Christian

C. Date of Delivery

11/18

- D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☒ No

3. Service Type

- ☐ Adult Signature
☐ Adult Signature Restricted Delivery
☒ Certified Mail®
☐ Certified Mail Restricted Delivery
☐ Collect on Delivery
☐ Collect on Delivery Restricted Delivery
☐ Insured Mail
☐ Mail Restricted Delivery (500)

- ☐ Priority Mail Express®
☐ Registered Mail™
☐ Registered Mail Restricted Delivery
☐ Return Receipt for Merchandise
☐ Signature Confirmation™
☐ Signature Confirmation Restricted Delivery

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3.

- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

SwedishAmerican Hospital
Mark Newton, President/CEO
1401 East State Street
Rockford, IL 61104-2298



9590 9403 0564 5173 9819 89

2. Article Number (Transfer from service label)

7005 3110 0003 2673 1658

PS Form 3811, April 2015 PSN 7530-02-000-9053

COMPLETE THIS SECTION ON DELIVERY

A. Signature

X *Tom Hooker*

☒ Agent

☐ Addressee

B. Received by (Printed Name)

Tom Hooker

C. Date of Delivery

11-14-17

- D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☒ No

3. Service Type

- ☐ Adult Signature
☐ Adult Signature Restricted Delivery
☒ Certified Mail®
☐ Certified Mail Restricted Delivery
☐ Collect on Delivery
☐ Collect on Delivery Restricted Delivery
☐ Insured Mail
☐ Mail Restricted Delivery (500)

- ☐ Priority Mail Express®
☐ Registered Mail™
☐ Registered Mail Restricted Delivery
☐ Return Receipt for Merchandise
☐ Signature Confirmation™
☐ Signature Confirmation Restricted Delivery

Domestic Return Receipt

ATTACHMENT 10

37

SENDER: COMPLETE THIS SECTION

■ Complete items 1, 2, and 3.

- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Presence Resurrection Medical Center:

John Baird, President/CEO

7435 West Talcott Avenue

Chicago, IL 60631-4455



9590 9403 0564 5173 9819 65

2. Article Number (Transfer from service label)

7005 3110 0003 2673 1627

PS Form 3811, April 2015 PSN 7530-02-000-9053

COMPLETE THIS SECTION ON DELIVERY

A. Signature

X

A. Kern

☐ Agent

☐ Addressee

B. Received by (Printed Name)

C. Date of Delivery

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

3. Service Type

☐ Adult Signature

☒ Adult Signature Restricted Delivery

☐ Certified Mail®

☐ Certified Mail Restricted Delivery

☐ Collect on Delivery

☒ Collect on Delivery Restricted Delivery

☐ Registered Mail™

☐ Registered Mail Restricted Delivery

☐ Priority Mail Express®

☐ Registered Mail™

☐ Registered Mail Restricted Delivery

☐ Return Receipt for Merchandise

☐ Signature Confirmation™

☐ Signature Confirmation Restricted Delivery

Domestic Return Receipt

ATTACHMENT 10

38

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

NorthShore HealthSystem
Highland Park Hospital
Jesse Peterson, President
777 Park Avenue West
Highland Park, IL 60035-2497

COMPLETE THIS SECTION ON DELIVERY

A. Signature

X

David J. Peterson

* Agent

☐ Addressee

B. Received by (Printed Name)

DAVID J. PETERSON

C. Date of Delivery

11-2-11

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

3. Service Type

☒ Certified Mail

☐ Express Mail

☐ Registered

☐ Return Receipt for Merchandise

☐ Insured Mail

☐ C.O.D.

4. Restricted Delivery? (Extra Fee)

☐ Yes

7014 0510 0000 1510 6159

PS Form 3811, February 2004

Domestic Return Receipt

102595-02-M-1840

39

ATTACHMENT 10

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Elmhurst Hospital
W. Peter Daniels, President/CEO
155 E. Brush Hill Road
Elmhurst, IL 60126



9590 9403 0564 5173 9820 23

2. Article Number (Transfer from service label)

7005 3110 0003 2673 1689

PS Form 3811, April 2016 PSN 7530-02-000-9053

Domestic Return Receipt

COMPLETE THIS SECTION ON DELIVERY

A. Signature

X *Tom McDermott* ☐ Agent ☒ Addressee

B. Received by (Printed Name)

Tom McDermott

C. Date of Delivery

- D. Is delivery address different from item 1?** ☐ Yes
If YES, enter delivery address below: ☐ No

3. Service Type

- | | |
|--|---|
| <input type="checkbox"/> Adult Signature | <input type="checkbox"/> Priority Mail Express® |
| <input type="checkbox"/> Adult Signature Restricted Delivery | <input type="checkbox"/> Registered Mail™ |
| <input checked="" type="checkbox"/> Certified Mail® | <input type="checkbox"/> Registered Mail Restricted Delivery |
| <input type="checkbox"/> Certified Mail Restricted Delivery | <input type="checkbox"/> Return Receipt for Merchandise |
| <input type="checkbox"/> Collect on Delivery | <input type="checkbox"/> Signature Confirmation™ |
| <input type="checkbox"/> Collect on Delivery Restricted Delivery | <input type="checkbox"/> Signature Confirmation Restricted Delivery |

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Shriners Hospitals for Children-Chicago
Jeffery Achmam, MD, Chief of Staff
2211 N. Oak Park Avenue
Chicago, IL 60707-3392



9590 9403 0564 5173 9819 72

2. Article Number (Transfer from service label)

7005 3110 0003 2673 1641

PS Form 3811, April 2016 PSN 7530-02-000-9053

COMPLETE THIS SECTION ON DELIVERY

A. Signature

X *V. Young* ☐ Agent ☒ Addressee

B. Received by (Printed Name)

V. Young

C. Date of Delivery

- D. Is delivery address different from item 1?** ☐ Yes
If YES, enter delivery address below: ☐ No

3. Service Type

- | | |
|--|---|
| <input type="checkbox"/> Adult Signature | <input type="checkbox"/> Priority Mail Express® |
| <input type="checkbox"/> Adult Signature Restricted Delivery | <input type="checkbox"/> Registered Mail™ |
| <input checked="" type="checkbox"/> Certified Mail® | <input type="checkbox"/> Registered Mail Restricted Delivery |
| <input type="checkbox"/> Certified Mail Restricted Delivery | <input type="checkbox"/> Return Receipt for Merchandise |
| <input type="checkbox"/> Collect on Delivery | <input type="checkbox"/> Signature Confirmation™ |
| <input type="checkbox"/> Collect on Delivery Restricted Delivery | <input type="checkbox"/> Signature Confirmation Restricted Delivery |

Domestic Return Receipt

ATTACHMENT 10

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Edward Hospital
Pam Davis, President/CEO
801 S. Washington Street
Naperville, IL 60540-7430



9590 9403 0564 5173 9820 16

2. Article Number (Transfer from service label)

7005 3110 0003 2673 1580

PS Form 3811, April 2015 PSN 7530-02-000-9053

COMPLETE THIS SECTION ON DELIVERY

A. Signature

X

- ☐ Agent
☐ Addressee

B. Received by (Printed Name)

Cedar Rapids

C. Date of Delivery

- D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

3. Service Type

- ☐ Adult Signature
☐ Adult Signature Restricted Delivery
☒ Certified Mail®
☐ Certified Mail Restricted Delivery
☐ Collect on Delivery
☐ Collect on Delivery Restricted Delivery

- ☐ Priority Mail Express®
☐ Registered Mail™
☐ Registered Mail Restricted Delivery
☐ Return Receipt for Merchandise
☐ Signature Confirmation™
☐ Signature Confirmation Restricted Delivery

Mail
Mail Restricted Delivery
(50)

Domestic Return Receipt

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Northwestern Medicine Central
DuPage Hospital
Brian Lemon, President/CEO
25 North Winfield Road
Winfield, IL 60190-1295



9590 9403 0564 5173 9820 09

2. Article Number (Transfer from service label)

7005 3110 0003 2673 1672

PS Form 3811, April 2015 PSN 7530-02-000-9053

COMPLETE THIS SECTION ON DELIVERY

A. Signature

X

- ☐ Agent
☐ Addressee

B. Received by (Printed Name)

Brian Lemon

C. Date of Delivery

11-14

- D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

3. Service Type

- ☐ Adult Signature
☐ Adult Signature Restricted Delivery
☒ Certified Mail®
☐ Certified Mail Restricted Delivery
☐ Collect on Delivery
☐ Collect on Delivery Restricted Delivery

- ☐ Priority Mail Express®
☐ Registered Mail™
☐ Registered Mail Restricted Delivery
☐ Return Receipt for Merchandise
☐ Signature Confirmation™
☐ Signature Confirmation Restricted Delivery

Mail
Mail Restricted Delivery
(500)

Domestic Return Receipt

ATTACHMENT 10

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Elmhurst Hospital
W. Peter Daniels, President/CEO
 155 E. Brush Hill Road
 Elmhurst, IL 60126



9590 9403 0564 5173 9820 23

2. Article Number (Transfer from service label)

7005 3110 0003 2673 1689

PS Form 3811, April 2015 PSN 7530-02-000-9053

Domestic Return Receipt

COMPLETE THIS SECTION ON DELIVERY

A. Signature

X *Tom McDermost* ☐ Agent ☒ Addressee

B. Received by (Printed Name)

Tom McDermost

C. Date of Delivery

D. Is delivery address different from item 1? ☐ Yes
 If YES, enter delivery address below: ☐ No

3. Service Type

- | | |
|--|---|
| <input type="checkbox"/> Adult Signature | <input type="checkbox"/> Priority Mail Express® |
| <input type="checkbox"/> Adult Signature Restricted Delivery | <input type="checkbox"/> Registered Mail™ |
| <input checked="" type="checkbox"/> Certified Mail® | <input type="checkbox"/> Registered Mail Restricted Delivery |
| <input type="checkbox"/> Certified Mail Restricted Delivery | <input type="checkbox"/> Return Receipt for Merchandise |
| <input type="checkbox"/> Collect on Delivery | <input type="checkbox"/> Signature Confirmation™ |
| <input type="checkbox"/> Collect on Delivery Restricted Delivery | <input type="checkbox"/> Signature Confirmation Restricted Delivery |
| <input type="checkbox"/> Mail Restricted Delivery | |

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Shriners Hospitals for Children-Chicago
Jeffery Achmam, MD, Chief of Staff
 2211 N. Oak Park Avenue
 Chicago, IL 60707-3392



9590 9403 0564 5173 9819 72

2. Article Number (Transfer from service label)

7005 3110 0003 2673 1641

PS Form 3811, April 2015 PSN 7530-02-000-9053

COMPLETE THIS SECTION ON DELIVERY

A. Signature

X *V. Young* ☐ Agent ☒ Addressee

B. Received by (Printed Name)

V. Young

C. Date of Delivery

D. Is delivery address different from item 1? ☐ Yes
 If YES, enter delivery address below: ☐ No

3. Service Type

- | | |
|--|---|
| <input type="checkbox"/> Adult Signature | <input type="checkbox"/> Priority Mail Express® |
| <input type="checkbox"/> Adult Signature Restricted Delivery | <input type="checkbox"/> Registered Mail™ |
| <input checked="" type="checkbox"/> Certified Mail® | <input type="checkbox"/> Registered Mail Restricted Delivery |
| <input type="checkbox"/> Certified Mail Restricted Delivery | <input type="checkbox"/> Return Receipt for Merchandise |
| <input type="checkbox"/> Collect on Delivery | <input type="checkbox"/> Signature Confirmation™ |
| <input type="checkbox"/> Collect on Delivery Restricted Delivery | <input type="checkbox"/> Signature Confirmation Restricted Delivery |
| <input type="checkbox"/> Mail Restricted Delivery | |

Domestic Return Receipt

ATTACHMENT 10

SENDER: COMPLETE THIS SECTION

- Complete Items 1, 2, and 3.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Edward Hospital
 Pam Davis, President/CEO
 801 S. Washington Street
 Naperville, IL 60540-7430



9590 9403 0564 5173 9820 16

2. Article Number (Transfer from service label)

7005 3110 0003 2673 1580

PS Form 3811, April 2015 PSN 7530-02-000-9053

COMPLETE THIS SECTION ON DELIVERY

A. Signature

X

- ☐ Agent
☐ Addressee

B. Received by (Printed Name)

Gloria Bejard

C. Date of Delivery

- D. Is delivery address different from item 1? ☐ Yes
 If YES, enter delivery address below: ☐ No

3. Service Type

- ☐ Adult Signature
☐ Adult Signature Restricted Delivery
☒ Certified Mail®
☐ Certified Mail Restricted Delivery
☐ Collect on Delivery
☐ Collect on Delivery Restricted Delivery
☐ Mail Restricted Delivery (500)

- ☐ Priority Mail Express®
☐ Registered Mail™
☐ Registered Mail Restricted Delivery
☐ Return Receipt for Merchandise
☐ Signature Confirmation™
☐ Signature Confirmation Restricted Delivery

Domestic Return Receipt

SENDER: COMPLETE THIS SECTION

- Complete Items 1, 2, and 3.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Northwestern Medicine Central
 DuPage Hospital
 Brian Lemon, President/CEO
 25 North Winfield Road
 Winfield, IL 60190-1295



9590 9403 0564 5173 9820 09

2. Article Number (Transfer from service label)

7005 3110 0003 2673 1672

PS Form 3811, April 2015 PSN 7530-02-000-9053

COMPLETE THIS SECTION ON DELIVERY

A. Signature

X

- ☐ Agent
☐ Addressee

B. Received by (Printed Name)

Brian Lemon

C. Date of Delivery

11-17

- D. Is delivery address different from item 1? ☐ Yes
 If YES, enter delivery address below: ☐ No

3. Service Type

- ☐ Adult Signature
☐ Adult Signature Restricted Delivery
☒ Certified Mail®
☐ Certified Mail Restricted Delivery
☐ Collect on Delivery
☐ Collect on Delivery Restricted Delivery
☐ Mail Restricted Delivery (500)

- ☐ Priority Mail Express®
☐ Registered Mail™
☐ Registered Mail Restricted Delivery
☐ Return Receipt for Merchandise
☐ Signature Confirmation™
☐ Signature Confirmation Restricted Delivery

Domestic Return Receipt

ATTACHMENT 10

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Advocate Good Shepherd Hospital
 Karen A. Lambert, President
 450 West Highway 22
 Barrington, IL 60010-1901

COMPLETE THIS SECTION ON DELIVERY

A. Signature

X

☐ Agent☐ Addressee

B. Received by (Printed Name)

C. Date of Delivery

D. Is delivery address different from item 1?

☐ Yes

If YES, enter delivery address below:

☐ No

3. Service Type

☒ Certified Mail☐ Express Mail☐ Registered☐ Return Receipt for Merchandise☐ Insured Mail☐ C.O.D.

4. Restricted Delivery? (Extra Fee)

☐ Yes

7014 0510 0000 1510 5671

PS Form 3811, February 2004

Domestic Return Receipt

102596-02-M-1540

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

West Suburban Medical Center
 Joseph Ottolino, CEO
 3 Erie Court
 Oak Park, IL 60302-2599

COMPLETE THIS SECTION ON DELIVERY

A. Signature

X

☒ Agent☐ Addressee

B. Received by (Printed Name)

C. Date of Delivery

D. Is delivery address different from item 1?

☐ Yes

If YES, enter delivery address below:

☐ No

3. Service Type

☒ Certified Mail☐ Express Mail☐ Registered☐ Return Receipt for Merchandise☐ Insured Mail☐ C.O.D.

4. Restricted Delivery? (Extra Fee)

☐ Yes

7001 1140 0001 6034 5937

PS Form 3811, February 2004

Domestic Return Receipt

102596-02-M-1540

ATTACHMENT 10

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Westlake Hospital
Mike DiTorco, CEO
1225 Lake Street
Melrose Park, IL 60160-4039

COMPLETE THIS SECTION ON DELIVERY

A. Signature ☒ Agent
X *[Signature]* ☐ Addressee

B. Received by (Printed Name) *[Signature]* C. Date of Delivery *11-16*

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

3. Service Type
☐ Certified Mail ☐ Express Mail
☐ Registered ☐ Return Receipt for Merchandise
☐ Insured Mail ☐ C.O.D.

4. Restricted Delivery? (Extra Fee) ☐ Yes

7001 1140 0001 6034 5944

PS Form 3811, February 2004

Domestic Return Receipt

102595-02-M-1540

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Advocate Good Samaritan Hospital
David Fox, President/CEO
3815 Highland Ave.
Downers Grove, IL 60515-159

COMPLETE THIS SECTION ON DELIVERY

A. Signature ☒ Agent
X *[Signature]* ☐ Addressee

B. Received by (Printed Name) *[Signature]* C. Date of Delivery *11-14-17*

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

3. Service Type
☐ Certified Mail ☐ Express Mail
☐ Registered ☐ Return Receipt for Merchandise
☐ Insured Mail ☐ C.O.D.

4. Restricted Delivery? (Extra Fee) ☐ Yes

7001 1140 0001 6034 5951

PS Form 3811, February 2004

Domestic Return Receipt

102595-02-M-1540

ATTACHMENT 10

SAFETY NET STATEMENT

The proposed project, which is limited to the discontinuation of AMITA Health Alexian Brothers Medical Center's ("ABMC's") inpatient pediatrics category of service will have no material impact on the provision of safety net services to the communities traditionally served by ABMC. Pediatric care is trending away from inpatient services, and the inpatient pediatric care continuing to be provided is gravitating toward "centers of excellence".

ABMC's sister hospital, AMITA Health St. Alexius Medical Center ("SAMC"), which is located less than ten miles away, offers a broad spectrum of primary and secondary care pediatric services on an inpatient as well as an outpatient basis. SAMC operates under the same admissions and charity care policies and under the same third party contracts as ABMC. As a result, members of the community will not experience any barriers to admission at SAMC as a result of the proposed discontinuation at ABMC. In addition, there are eighteen other hospitals providing inpatient pediatric care located within a 45 minute travel time, each with excess capacity.

It is not anticipated that the proposed discontinuation will result in any substantive impact on any other provider, due in part to the low number of pediatric admissions experienced by ABMC. During 2016, ABMC averaged only 3.5 pediatric admissions a week.

E-052-17
Axel & Associates, Inc.

MANAGEMENT CONSULTANTS

December 12, 2017

Ms. Courtney Avery
Administrator
Illinois Health Facilities and
Services Review Board
525 West Jefferson
Springfield, IL 62761

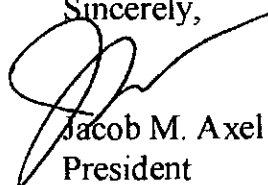
RECEIVED
DEC 13 2017
HEALTH FACILITIES &
SERVICES REVIEW BOARD

Dear Courtney:

Enclosed please find two copies of a Certificate of Exemption application addressing the discontinuation of AMITA Health Alexian Brothers Medical Center's 16-bed inpatient pediatrics unit in Elk Grove Village, Illinois. Also enclosed is a check, in the amount of \$2,500.00, as a filing fee.

Should any additional information be required, please do not hesitate to contact me.

Sincerely,



Jacob M. Axel
President

enclosures